

## **Title 23: Division of Medicaid**

### **Part 220: Radiology**

#### **Part 220 Chapter 1: General**

##### *Rule 1.2: Prior Authorization*

- A. Effective July 1, 2013, prior authorization is required by the radiology Utilization Management/Quality Improvement Organization (UM/QIO) for medical necessity and appropriateness of the service for the following advanced imaging procedures:
  - 1. Computed Tomography (CT) Scans and Computed Tomography Angiography (CTA),
  - 2. Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA),
  - 3. Positron Emission Tomography (PET) Scans, and
  - 4. Nuclear Cardiac Imaging Studies.
- B. Prior Authorization for the advanced imaging procedures listed in Rule 1.2.A. is required in all settings except in an:
  - 1. Inpatient hospital,
  - 2. Emergency room, or
  - 3. Outpatient hospital twenty-three (23) hour observation period.
- C. The prior authorization request must be submitted by either the ordering or the rendering provider.
  - 1. The provider must submit documentation indicating medical necessity and appropriateness of the service to the radiology UM/QIO, including, but not limited to, the:
    - a) Results of a recent clinical evaluation,
    - b) Diagnosis or clinical condition which the imaging evaluation is being ordered,
    - c) Treatment history related to the stated diagnosis or clinical condition,
    - d) Treatment plan related to the stated diagnosis or clinical condition, and
    - e) Previous imaging results related to the stated diagnosis or clinical condition.

2. Medical necessity and appropriateness of the service is based on nationally-accepted guidelines and radiology protocols based on peer reviewed literature for urgent, emergent and non-emergent services including, but not limited to, the:
  - a) Division of Medicaid's radiology UM/QIO Clinical Decision Support Tool for Advanced Diagnostic Imaging,
  - b) American College of Radiology's Appropriateness Criteria,
  - c) American Academy of Neurology,
  - d) American Academy of Orthopedic Surgeons,
  - e) American College of Cardiology,
  - f) American Heart Association, and/or
  - g) National Comprehensive Cancer Care Network.
- D. Prior authorization must be received by the provider before the procedure is rendered except in medically urgent situations.
- E. In the event of a medical emergent condition or situation a retrospective review may be requested.
  1. The request must be received by the radiology UM/QIO within three (3) business days from the date of service.
  2. The Division of Medicaid defines a medical emergent condition or situation as one which:
    - a) The patient faces immediate risk of loss of life or limb,
    - b) Could seriously jeopardize the life or health of the beneficiary or their ability to regain maximum function based on a prudent layperson's judgment, or
    - c) In the opinion of a practitioner with knowledge of the beneficiary's medical condition, would subject the beneficiary to severe pain that cannot be adequately managed without the requested advanced imaging procedure.

Source: Miss. Code Ann. § 43-13-121, 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.2.C. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.7: Computed Tomography (CT) Scans and Computed Tomography Angiography (CTA)*

- A. Effective July 1, 2013, Computed Tomography (CT) scans and Computed Tomography Angiography (CTA), with or without contrast, must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.
- B. The Division of Medicaid does not cover:
  - 1. A limited or follow-up CT scan for any given area of the body during the same encounter as a full diagnostic CT scan,
  - 2. A two (2)-dimensional rendering after a three (3)-dimensional rendering of a CT scan,
  - 3. A CT/SPECT (Single Photon Emission Computed Tomography) nuclear medicine imaging only for:
    - a) Localization, or
    - b) Attenuation correction purposes,
  - 3. A whole body CT for screening of asymptomatic beneficiaries, or
  - 4. The performance of CT screenings in healthy beneficiaries.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.7.B. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.8: Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI)*

- A. Effective July 1, 2013, Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI), with or without contrast, must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.
- B. The Division of Medicaid covers a functional MRI when used as part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, which might potentially be put at risk during the proposed surgery.
- C. The Division of Medicaid does not cover an MRA or MRI for:
  - 1. Screening of asymptomatic beneficiaries,
  - 2. Screening of healthy beneficiaries, or

3. A two (2)-dimensional rendering after a three (3)-dimensional rendering has been performed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.8.B. and C. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.9: Positron Emission Tomography (PET) Scans*

- A. Effective July 1, 2013, Positron Emission Tomography (PET) scans must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.
- B. The Division of Medicaid covers one (1) fluorodeoxyglucose (FDG) PET scan for solid tumors, myeloma or lymphoma that are biopsy proven or strongly suspected based on other diagnostic testing for the following therapeutic purposes related to the initial treatment strategy to determine:
  1. Whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure,
  2. Optimal anatomic location for an invasive procedure, or
  3. The anatomic extent of a tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.
- C. The Division of Medicaid covers PET scans for initial anti-tumor treatment strategy, formerly “diagnosis” and “staging”, for the following oncologic conditions:
  1. Thyroid cancer,
  2. Non-small cell, lung cancer,
  3. Colorectal cancer,
  4. Melanoma,
  5. Lymphoma,
  6. Head and neck cancer, excluding thyroid and central nervous system,
  7. Esophageal cancer,
  8. Male and female breast cancer when used in staging distant metastasis,

9. Cervical cancer that is newly diagnosed following conventional imaging that is negative for extra-pelvic metastasis,
  10. Ovarian cancer,
  11. Testicular cancer,
  12. Brain cancer,
  13. Pancreatic cancer, or
  14. Soft tissue carcinoma,
- D. The Division of Medicaid does not cover PET scans for the initial anti-tumor treatment strategy, formerly “diagnosis” and “staging”, for the:
1. Initial diagnosing of breast cancer or the initial staging of axillary nodes,
  2. Initial diagnosing of cervical cancer,
  3. Evaluation of regional lymph nodes in melanoma, or
  4. Diagnosis of adenocarcinoma of the prostate.
- E. The Division of Medicaid covers PET scans for subsequent anti-tumor treatment strategy, formerly “restaging” and “monitoring response to treatment”, after the completion of the initial treatment course for the following oncologic conditions:
1. Breast cancer,
  2. Colorectal cancer,
  3. Esophageal cancer,
  4. Head and neck (non-CNS/thyroid), excluding thyroid and central nervous system,
  5. Lymphoma,
  6. Melanoma,
  7. Non-small cell lung cancer,
  8. Thyroid cancer,
  9. Ovarian cancer,

10. Cervical cancer, or

11. Myeloma.

F. The Division of Medicaid covers FDG-PET scans for refractory seizures only for pre-surgical evaluation of localization of a focus of refractory seizure activity.

G. The Division of Medicaid does not cover PET scans for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Revised Rule 1.9. B. – E. and added G. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.10: Nuclear Cardiac Imaging Studies*

A. Effective July 1, 2013, nuclear cardiac imaging studies must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.

B. The Division of Medicaid covers the following nuclear cardiac imaging:

1. Perfusion of the heart, either at rest or with pharmacological stress, for the diagnosis and management of beneficiaries with known or suspected coronary artery disease when one (1) of the following criteria are met:

a) The PET scan, whether at rest alone or at rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT) scan, or

b) The PET scan, whether at rest alone or at rest with stress, is performed following an inconclusive SPECT scan.

1) The PET scan must be considered medically necessary to determine what medical or surgical intervention is required to treat the beneficiary.

2) The Division of Medicaid defines an inconclusive SPECT scan as a test(s) whose results are equivocal, technically uninterpretable, or discordant with a beneficiary's other clinical data documentation in the beneficiary's medical record.

2. For the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization or following an inconclusive SPECT.

a) A SPECT scan is not covered following an inconclusive PET scan.

b) Refer to Rule 1.10.B.1.b) 2).

C. The Division of Medicaid does not cover a SPECT/CT (Single Photon Emission Computed Tomography) which involves a SPECT multi-planar imaging (MPI) nuclear medicine scan only for:

- 1) Localization,
- 2) Accuracy, and
- 3) Attenuation correction purposes.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.10.C. eff. 01/01/2014.

*Rule 1.11: Documentation*

A. Documentation for advanced imaging procedures must:

1. Include the referring physician's documentation of medical necessity and criteria met in Rule 1.2,
2. Not duplicate other covered diagnostic tests,
3. Be maintained in the referring physician's file.
4. Include documentation the procedure involved only FDA approved drugs and devices and did not involve investigational drugs, as determined by the FDA,
5. Support the referral to the rendering provider, and
6. Be maintained in accordance with Part 200, Chapter 3, Rule 1.3.

B. Providers and facilities are subject to on-site and documentation reviews of technical and professional imaging services and are reimbursed only for procedures, products, and services within the scope of the provider's clinical practice.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 431.10(e).

History: Added Rule 1.11 eff. 01/01/2014.

## **Title 23: Division of Medicaid**

### **Part 220: Radiology**

#### **Part 220 Chapter 1: General**

*Rule 1.2: ~~Positron Emission Tomography (PET) Scans~~(A.- F. Moved to Rule 1.8 and amended)*

- ~~A. Effective July 1, 2013, Positron Emission Tomography (PET) scans must be prior authorized by the radiology Utilization Management/Quality Improvement Organization (UM/QIO) as noted in Rule 1.10.~~
- ~~B. PET Scans are covered by Medicaid for beneficiaries with the malignant cancers listed in Part 220, Rule 1.2.B for the following reasons:~~
- ~~1. Initial diagnosis,~~
  - ~~2. Staging when there is documented evidence of a primary tumor by CT, MRI, X-ray, or tissue sample,~~
  - ~~3. Restaging after a course of treatment,~~
  - ~~4. Evaluating recurrence prior to surgery as an alternative to gallium scan but is not covered for evaluating regional nodes, or~~
  - ~~5. In lieu of other modalities such as CT, MRI, and X-ray.~~
- ~~C. PET scans are covered by Medicaid for beneficiaries with tumors with the following malignant cancers for the reasons listed in Part 220, Chapter 1, Rule 1.2.A:~~
- ~~1. Characterization of solitary pulmonary nodules (SPN's),~~
  - ~~2. Lung cancer, non-small cell,~~
  - ~~3. Colorectal cancer,~~
  - ~~4. Melanoma,~~
  - ~~5. Lymphoma when used as an alternative to gallium scan,~~
  - ~~6. Head and neck cancer, excluding thyroid and central nervous system, and~~
  - ~~7. Esophageal cancer.~~
- ~~D. PET scans are covered for beneficiaries with breast cancer only for the following reasons:~~



- ~~1. Staging with distant metastasis,~~
  - ~~2. Restaging with loco-regional recurrence or metastasis, or~~
  - ~~3. Monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated.~~
- ~~E. PET scans are covered for beneficiaries with thyroid cancer for staging of recurrent or residual thyroid cancers of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan.~~
- ~~F. PET scans are not covered for the:~~
- ~~1. Initial diagnosing of breast cancer, or~~
  - ~~2. Initial diagnosing or restaging of thyroid cancer.~~
- ~~G. PET scans are covered for the following myocardial imaging: (Moved to 1.10)~~
- ~~1. Perfusion of the heart, either at rest or with pharmacological stress, for the diagnosis and management of beneficiaries with known or suspected coronary artery disease using the Federal Drug Administration (FDA) approved radiopharmaceutical Rubidium 82 (Rb-82) or ammonia N-13 tracer when one (1) of the following criteria are met:~~
    - ~~a) The PET scan, whether at rest alone or at rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT) scan, or~~
    - ~~b) The PET scan, whether at rest alone or at rest with stress, is performed following an inconclusive SPECT scan.~~
      - ~~1) The PET scan must be considered medically necessary to determine what medical or surgical intervention is required to treat the beneficiary.~~
      - ~~2) The Division of Medicaid defines an inconclusive SPECT scan as a test(s) whose results are equivocal, technically uninterpretable, or discordant with a beneficiary's other clinical data documentation in the beneficiary's medical record.~~
  - ~~2. Myocardial viability using [18F] fluorodeoxyglucose (FDG) PET for the determination of myocardial viability or following an inconclusive SPECT prior to revascularization.~~
    - ~~a) A SPECT scan is not covered following an inconclusive PET scan.~~
    - ~~b) Refer to Rule 1.2.F.(2).~~

~~G. FDG PET scans are covered for refractory seizures only for pre-surgical evaluation of localization of a focus of refractory seizure activity. (Moved to Rule 1.8)~~

~~H. Documentation for all PET scans must: (Moved to Rule 1.11)~~

- ~~1. Include the referring physician's documentation of medical necessity and criteria met in Rule 2.1.A-G,~~
- ~~2. Not duplicate other covered diagnostic tests,~~
- ~~3. Be maintained in the referring physician's file.~~
- ~~4. Include documentation the procedure involved only FDA approved drugs and devices and did not involve investigational drugs, as determined by the FDA,~~
- ~~5. Support the referral to the PET scan provider, and~~
- ~~6. Be maintained in accordance with Part 200, Chapter 3, Rule 1.3.~~

~~Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).~~

~~History: Added Rule 1.2.A. to correspond with approved SPA 2013-007 effective 07/01/2013.~~

*Rule 1.2: Prior Authorization (Moved from Rule 1.10 with added language)*

A. Effective July 1, 2013, prior authorization is required by the radiology Utilization Management/Quality Improvement Organization (UM/QIO) for medical necessity and appropriateness of the service for the following advanced imaging procedures:

1. Computed Tomography (CT) Scans and Computed Tomography Angiography (CTA),
2. Magnetic Resonance Imaging (MRI), and
3. Magnetic Resonance Angiography (MRA),
43. Positron Emission Tomography (PET) Scans, and
54. Nuclear Cardiac Imaging Studies.

B. Prior Authorization for the advanced imaging procedures listed in Rule 1.402 .A is required in all settings except in an:

1. Inpatient hospital,
2. Emergency room, or
3. Outpatient hospital twenty-three (23) hour observation period.

C. The prior authorization request must be submitted by either the ordering or the rendering provider.

1. The provider must submit documentation indicating medical necessity and appropriateness of the service to the radiology UM/QIO, including, but not limited to, the:

- a) Results of a recent clinical evaluation,
- b) Diagnosis or clinical condition which the imaging evaluation is being ordered,
- c) Treatment history related to the stated diagnosis or clinical condition,
- d) Treatment plan related to the stated diagnosis or clinical condition, and
- e) Previous imaging results related to the stated diagnosis or clinical condition.

2. Medical necessity and appropriateness of the service is based on nationally-accepted guidelines and radiology protocols based on peer reviewed literature for urgent, emergent and non-emergent services including, but not limited to the:

- a) Division of Medicaid's radiology UM/QIO Clinical Decision Support Tool for Advanced Diagnostic Imaging,
- b) American College of Radiology's Appropriateness Criteria,
- c) American Academy of Neurology,
- d) American Academy of Orthopedic Surgeons,
- e) American College of Cardiology,
- f) American Heart Association, and/or
- g) National Comprehensive Cancer Care Network.

D. Prior authorization must be received by the provider before the procedure is rendered except in medically urgent situations.

E. In the event of a medical emergent condition or situation a retrospective review may be requested.

1. The request must be received by the radiology UM/QIO within three (3) business days from the date of service.

2. The Division of Medicaid defines a medical emergent condition or situation as one which:

- a) The patient faces immediate risk of loss of life or limb,
- b) Could seriously jeopardize the life or health of the beneficiary or their ability to regain maximum function based on a prudent layperson's judgment, or
- c) In the opinion of a practitioner with knowledge of the beneficiary's medical condition, would subject the beneficiary to severe pain that cannot be adequately managed without the requested advanced imaging procedure.

Source: Miss. Code Ann. § 43-13-121, 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.2.C. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.7: Computed Tomography (CT) Scans and Computed Tomography Angiography (CTA)*

A. Effective July 1, 2013, Computed Tomography (CT) scans and Computed Tomography Angiography (CTA), with or without contrast, must be prior authorized by the radiology UM/QIO as noted in Rule 1.402.

B. The Division of Medicaid does not cover:

- 1. A limited or follow-up CT scan for any given area of the body during the same encounter as a full diagnostic CT scan,
- 2. A two (2)-dimensional rendering after a three (3)-dimensional rendering of a CT scan.
- 3. A CT/SPECT (Single Photon Emission Computed Tomography) nuclear medicine imaging only for:
  - a) Localization, or
  - b) Attenuation correction purposes,
- 3. A whole body CT for screening of asymptomatic beneficiaries, or
- 4. The performance of CT screenings in healthy beneficiaries.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.7.B. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.8: Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI)*

- A. Effective July 1, 2013, Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI), with or without contrast, must be prior authorized by the radiology UM/QIO as noted in Rule 1.402.
- B. The Division of Medicaid covers a functional MRI when used as part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, which might potentially be put at risk during the proposed surgery.
- C. The Division of Medicaid does not cover an MRA or MRI for:
1. Screening of asymptomatic beneficiaries,
  2. Screening of healthy beneficiaries, or
  3. A two (2)-dimensional rendering after a three (3)-dimensional rendering has been performed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.8.B. and C. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.9: Magnetic Resonance Imaging (MRI) (Moved to Rule 1.8)*

~~Effective July 1, 2013, Magnetic Resonance Imaging must be prior authorized by the radiology UM/QIO as noted in Rule 1.10.~~

~~Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).~~

~~History: Added to correspond with approved SPA 2013-007 effective 07/01/2013~~

*Rule 1.9: Positron Emission Tomography (PET) Scans (Moved from Rule 1.2 and amended)*

- A. Effective July 1, 2013, Positron Emission Tomography (PET) scans must be prior authorized by the radiology UM/QIO as noted in Rule 1.402.
- B. The Division of Medicaid covers one (1) fluorodeoxyglucose (FDG) PET scan for solid tumors, myeloma or lymphoma that are biopsy proven or strongly suspected based on other diagnostic testing for the following therapeutic purposes related to the initial treatment strategy to determine:
1. Whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure, or

2. Optimal anatomic location for an invasive procedure, or

3. The anatomic extent of a tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.

~~B. PET Scans are covered by Medicaid for beneficiaries with the malignant cancers listed in Part 220, Rule 1.2.B for the following reasons:~~

~~1. Initial diagnosis,~~

~~2. Staging when there is documented evidence of a primary tumor by CT, MRI, X-ray, or tissue sample,~~

~~3. Restaging after a course of treatment,~~

~~4. Evaluating recurrence prior to surgery as an alternative to gallium scan but is not covered for evaluating regional nodes, or~~

~~5. In lieu of other modalities such as CT, MRI, and X-ray.~~

~~C. The Division of Medicaid covers PET scans for initial anti-tumor treatment strategy, formerly “diagnosis” and “staging”, for PET scans are covered by Medicaid for beneficiaries with tumors with the following malignant cancers oncologic conditions :for the reasons listed in Part 220, Chapter 1, Rule 1.2.A:~~

~~1. Characterization of solitary pulmonary nodules (SPN's); Thyroid cancer,~~

~~2. Lung cancer, Non-small cell, lung cancer~~

~~3. Colorectal cancer,~~

~~4. Melanoma,~~

~~5. Lymphoma when used as an alternative to gallium scan,~~

~~6. Head and neck cancer, excluding thyroid and central nervous system, and~~

~~7. Esophageal cancer,-~~

~~8. Male and female breast cancer when used in staging distant metastasis,~~

~~9. Cervical cancer that is newly diagnosed following conventional imaging that is negative for extra-pelvic metastasis,~~

~~10. Ovarian cancer,~~

11. Testicular cancer,
12. Brain cancer,
13. Pancreatic cancer, or
14. Soft tissue carcinoma.

~~D. PET scans are covered for beneficiaries with breast cancer only for the following reasons:~~

- ~~1. Staging with distant metastasis,~~
- ~~2. Restaging with loco-regional recurrence or metastasis, or~~
- ~~3. Monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated.~~

~~E. PET scans are covered for beneficiaries with thyroid cancer for staging of recurrent or residual thyroid cancers of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan.~~

~~DF. The Division of Medicaid does not cover PET scans for the initial anti-tumor treatment strategy, formerly “diagnosis” and “staging”, are not covered for the:~~

1. Initial diagnosing of breast cancer or the initial staging of axillary nodes,
- ~~2. Initial diagnosing or restaging of thyroid cancer.~~
2. Initial diagnosing of cervical cancer,
3. Evaluation of regional lymph nodes in melanoma, or
4. Diagnosis of adenocarcinoma of the prostate.

E. The Division of Medicaid covers PET scans for subsequent anti-tumor treatment strategy, formerly “restaging” and “monitoring response to treatment”, after the completion of the initial treatment course for the following oncologic conditions:

1. Breast cancer,
2. Colorectal cancer,
3. Esophageal cancer,

4. Head and neck (~~non-CNS/thyroid~~); excluding thyroid and central nervous system.
5. Lymphoma,
6. Melanoma,
7. Non-small cell lung cancer,
8. Thyroid cancer,
9. Ovarian cancer,
10. Cervical cancer, or
11. Myeloma.

F.~~G.~~The Division of Medicaid covers FDG-PET scans ~~are covered~~ for refractory seizures only for pre-surgical evaluation of localization of a focus of refractory seizure activity.

G. The Division of Medicaid does not cover PET scans for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Revised Rule 1.9. B. – E. and added G. eff. 01/01/02014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.10: (~~Moved to Rule 1.2 and amended~~) ~~Prior Authorization~~*

~~A. Effective July 1, 2013, prior authorization is required by the radiology UM/QIO for medical necessity and appropriateness of the service for the following advanced imaging procedures:~~

- ~~1. Computed Tomography (CT) Scans,~~
- ~~2. Magnetic Resonance Imaging (MRI),~~
- ~~3. Magnetic Resonance Angiography (MRA),~~
- ~~4. Positron Emission Tomography (PET) Scans, and~~
- ~~5. Nuclear Cardiac Studies.~~

~~B. Prior Authorization for advanced imaging procedures listed in Rule 1.10 A is required in all settings except in an:~~

- ~~1. Inpatient hospital,~~



~~2. Emergency room, or~~

~~3. Outpatient hospital twenty three (23) hour observation period.~~

~~C. The prior authorization must be requested by either the ordering or rendering provider.~~

~~D. Prior authorization must be received prior to the procedure being rendered except in medically urgent situations.~~

~~E. In the event of a medical emergent condition or situation a retrospective review may be requested.~~

~~1. The request must be received by the radiology UM/QIO within three (3) business days from the date of service.~~

~~2. The Division of Medicaid defines a medical emergent condition or situation as one which:~~

~~a) The patient faces immediate risk to loss of life or limb,~~

~~b) Could seriously jeopardize the life or health of the beneficiary or their ability to regain maximum function based on a prudent layperson's judgment, or~~

~~c) In the opinion of a practitioner with knowledge of the beneficiary's medical condition, would subject the beneficiary to severe pain that cannot be adequately managed without the requested advanced imaging procedure.~~

Source: ~~Miss. Code Ann. § 43-13-121, 42 CFR §§ 431.10(e), 440.230(d)~~

History: ~~Added to correspond with approved SPA 2013-007 effective 07/01/2013.~~

*Rule 1.10: Nuclear Cardiac Imaging Studies (Moved from Rule 1.2.G.)*

A. Effective July 1, 2013, Nuclear cardiac imaging studies must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.

~~GB. The Division of Medicaid covers PET scans are covered for the following nuclear cardiac myocardial imaging:~~

1. Perfusion of the heart, either at rest or with pharmacological stress, for the diagnosis and management of beneficiaries with known or suspected coronary artery disease ~~using the Federal Drug Administration (FDA) approved radiopharmaceutical Rubidium 82 (Rb 82) or ammonia N-13 tracer~~ when one (1) of the following criteria are met:

a) The PET scan, whether at rest alone or at rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT) scan, or

b) The PET scan, whether at rest alone or at rest with stress, is performed following an inconclusive SPECT scan.

1) The PET scan must be considered medically necessary to determine what medical or surgical intervention is required to treat the beneficiary.

2) The Division of Medicaid defines an inconclusive SPECT scan as a test(s) whose results are equivocal, technically uninterpretable, or discordant with a beneficiary's other clinical data documentation in the beneficiary's medical record.

2. Myocardial viability using [18F] fluorodeoxyglucose (FDG) PET for the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization or following an inconclusive SPECT prior to revascularization.

a) A SPECT scan is not covered following an inconclusive PET scan.

b) Refer to Rule 1.10.B.1.b) 2).

C. The Division of Medicaid does not cover a SPECT/CT (Single Photon Emission Computed Tomography) which involves a SPECT multi-planar imaging (MPI) nuclear medicine scan only for:

1) Localization,

2) Accuracy, and

3) Attenuation correction purposes.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.10.C. eff. 01/01/2014.

*Rule 1.11: Documentation (Moved from 1.2.H)*

A. Documentation for advanced imaging procedures must:

1. Include the referring physician's documentation of medical necessity and criteria met in Rule 1.2,

2. Not duplicate other covered diagnostic tests,

3. Be maintained in the referring physician's file.

4. Include documentation the procedure involved only FDA approved drugs and devices and did not involve investigational drugs, as determined by the FDA,
  5. Support the referral to the rendering provider, and
  6. Be maintained in accordance with Part 200, Chapter 3, Rule 1.3.
- B. Providers and facilities are subject to on-site and documentation reviews of technical and professional imaging services and are reimbursed only for procedures, products, and services within the scope of the provider's clinical practice.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 431.10(e).

History: Added Rule 1.11 eff. 01/01/2014.